

AUTHORIZATION FOR EXAMINATION AND/OR TREATMENT OF A MINOR

		, tł	, the parent and/or legal guardian			
	Printed Name of Parent or Legal Guardian					
of						
	Name of Child/Minor (patient)		Date of Birth			
hereby give consent to the examination and/or treatment of my child/minor during the office visits.						
This a	uthorization:					
0	Is effective only on:		, 2	0		
0	Is effective from:, 2	0	to	;	20	
0	Is effective until revoked by me in writing					
Signature of Parent/Legal Guardian			Date		Time	
The CHI Health Witness			Date		Time	
Second CHI Health Witness – if telephone consent			Date		Time	